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November 15, 2016

The Honorable Michael J. Missal
Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Inspector General Missal:

I cannot begin to describe my continued frustration, disappointment, and sadness that I must again write to you demanding answers about the loss of yet another promising, young Iowa veteran. Just as I wrote in February 2015, and yet again in July of this year, I am increasingly concerned about the mental health care treatment and subsequent recovery coordination provided to our veterans through the Department of Veterans Affairs (VA). Expanding recovery and coordination activities for patients with Post-Traumatic Stress Disorder (PTSD), as well as improving care management service, is something I fear is not happening quickly enough in the VA healthcare system.

In February of 2015, I wrote to then Acting Inspector General, Mr. Richard Griffin, expressing great concern over the death of Richard Miles, an Iraq War veteran who was found dead at Water Works Park in Des Moines, Iowa. Prior to taking his own life, Mr. Miles sought mental health treatment from the VA. Immediately following Mr. Miles' death, I requested that your office investigate the VA Central Iowa Health Care System's mental health program, and I instructed my staff to monitor and assist in the investigation as necessary. The investigation concluded that Mr. Miles had not received adequate mental health care from the VA.

In July of 2016, the VA's mental health care services failed another Iowa veteran, Mr. Brandon Ketchum. Mr. Ketchum, a combat veteran who served in both the Marine Corps and Army National Guard, sought mental health care from a psychiatrist at the Iowa City VA Medical Center. Despite having been flagged for suicide risk multiple times in the past, the VA denied Mr. Ketchum the healthcare services he urgently needed and requested.

I write to you today because during the week of Veterans Day, I learned that yet another Iowa veteran, a young soldier by the name of Curtis Gearhart, committed suicide after the VA allegedly failed to provide timely care. Mr. Gearhart served two tours in Iraq as a combat engineer, the same theater we are sending our young men and woman to today. It is being reported that Mr. Gearhart was told to wait more than a month for treatment, despite needing health care attention immediately.

Mr. Gearhart, Mr. Ketchum, Mr. Miles, and all of our veterans we've tragically lost to suicide, deserved better from the VA. It is unacceptable that veterans are being told to wait, especially

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available to them outside of the VA. It is simply unacceptable that anyone who has courageously served this great nation is sent home without being given options that exist for receiving qualified, outside care. I simply cannot accept that the Iowa VAs continue to allow veterans such as Mr. Gearhart to slip through the cracks of the system.

Additionally, I find alarming that despite the VA's rhetoric of being "open and transparent", I have not been able to get basic information regarding Mr. Gearhart's care. While hiding behind the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the VA claims to not be able to share any information. Even though Mr. Ketchum posted that the VA refused to provide him treatment on Facebook, the VA still only gave basic information to the Congressional delegation. I am extremely disappointed that it appears the VA only offers information when they are required to go on the defensive to counter posts that have exposed their failures on social media platforms, such as Facebook. Instead of worrying about public appearance, the VA should make an effort to work with Congress to address the tragedy at hand, regardless of the media coverage. The lives of our veterans come before the VA's public relations front.

I demand that the VA OIG conduct a thorough investigation into the death of Mr. Curtis Gearhart, focusing both on why Mr. Gearhart was denied care, and what steps must be taken to prevent this from happening ever again. I hope I make myself clear when I say, I do not want to have to write to you again regarding the loss of yet another Iowa veteran who has died because they did not receive adequate care from the VA.

I remain committed to working to end the epidemic of veteran suicide. I urge you to work to improve veterans' services at the Veterans Health Administration throughout Iowa, but also nationwide. In addition to the results of your thorough investigation, I expect a written response from your office detailing concrete steps that will be taken to prevent tragedies such as Mr. Gearhart's from ever happening again. As you know, this Administration is quickly coming to a close and I expect to see a response before the end of the year. I speak for all Iowans when I say that our veterans deserve better.

If you have any questions concerning this request, please contact my staff via Katherina Dimenstein at (202) 224 -3254 or Katherina_Dimenstein@Ernst.Senate.Gov.

Sincerely,

Joni K. Ernst

Joni K. Ernst
United States Senator